WRONG MEDICATION, LACK OF MONITORING LEAD TO PATIENT DEATH

Cause Map

1 Problem

What	Problem(s)	Patient death, medication error
When	Date	December 3, 2014
	Time	Morning (patient death)
	Different, unusual, unique	Fire alarm (code red) at facility
Where	Facility, site	Bend, Oregon
	Unit, area, equipment	Hospital emergency room
	Task being performed	Administration of IV anti-seizure medication

Impact to the Goals

Goal	Impact
Patient Safety	Patient death
Employee	3 employees placed on administrative leave
Environmental	?
Compliance	"Never event"
Patient Services	Patient not monitored after IV administration
Schedule/ Operations	?
Property/ Equipment	?
Labor/ Time	Investigation

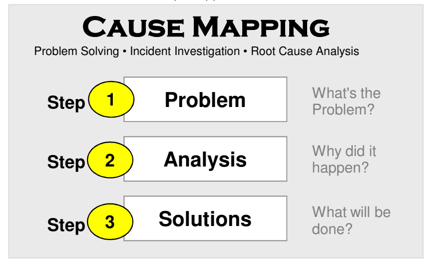
Frequency	First time hospital has had issue like this

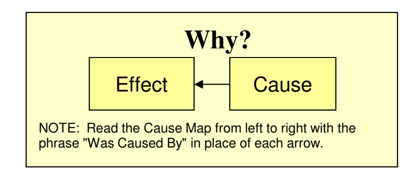
A hospital in Oregon administered the wrong medication to a patient who stopped breathing. Because of a fire alarm that happened shortly afterwards, the patient was not monitored for about twenty minutes. After that time the patient had experienced irreversible brain damage and was taken off life support.

"We want the community to know what happened. Precautions need to be taken. The only message we really have is that life is short and you never know when something like this could happen."

- Mark Macpherson, victim's son

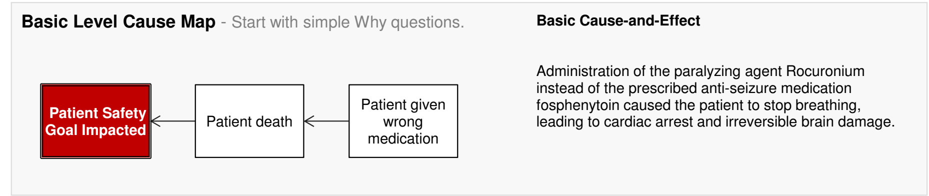
Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.





"We're looking for any gaps or weaknesses in the process, or to see if there has been any human error involved." - Dr. Michel Boileau, Chief Clinical Officer

2 Analysis



Basic Cause-and-Effect

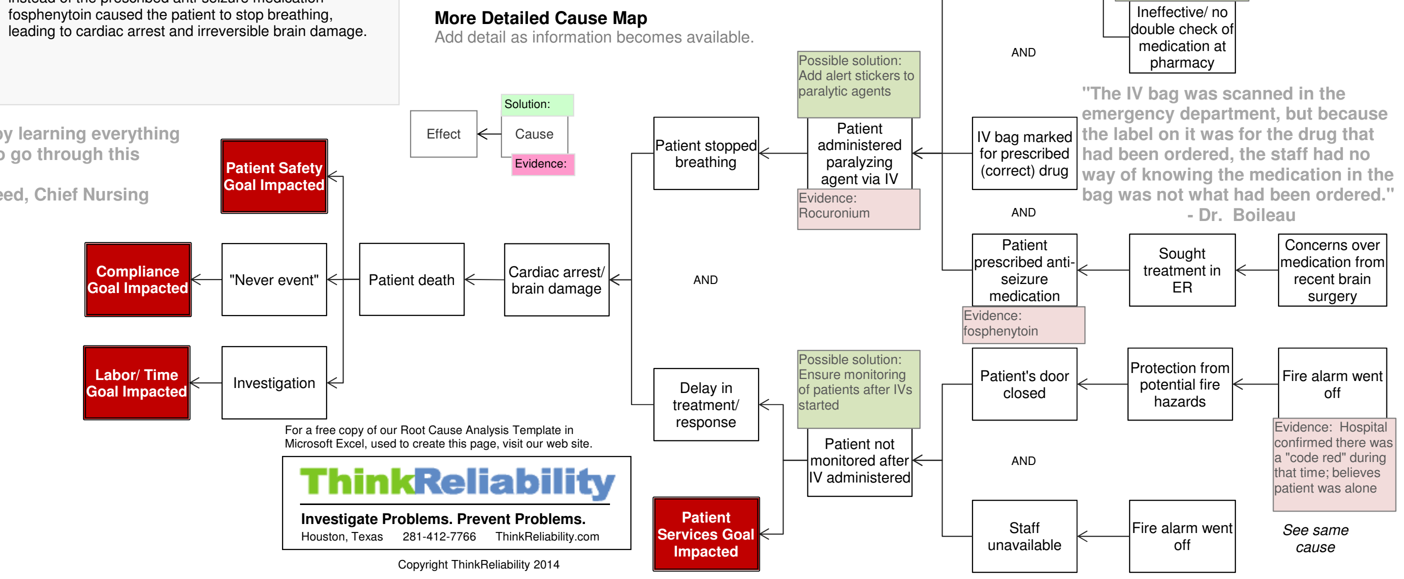
Administration of the paralyzing agent Rocuronium instead of the prescribed anti-seizure medication fosphenytoin caused the patient to stop breathing, leading to cardiac arrest and irreversible brain damage.

More Detailed Cause Map

Add detail as information becomes available.

"We are all committed to honoring Ms. Macpherson's name by learning everything there is to learn here and making sure no other patient has to go through this again."

- Karen Reed, Chief Nursing



3 Solutions

No.	Action Item	Cause
1	Implementation of safety zone for medication verification	Wrong medication put in IV bag in pharmacy
2	Review/ update medication protocols	
3	Implementation of detailed checking process	Ineffective/ no double check of medication at pharmacy
4	Add alert stickers to paralytic agents	Patient administered paralyzing agent via IV
5	Ensure monitoring of patients after IVs started	Patient not monitored after IV administered

For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

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